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# A BRIDGE OVER TROUBLED WATERS: THE DEVELOPMENT OF MEDICAL MALPRACTICE LITIGATION IN BRAZIL

EDUARDO DANTAS\*

## INTRODUCTION

Medicine has been evolving in leaps, and the practical consequence for that is changing of social behavior, the creation of new practices, and the need to deal with dilemmas once only a product of science fiction. In vitro fertilization, cloning techniques, the manipulation of stem cells, genetic engineering, nanotechnology, and the deciphering of the human genome are just part of an almost endless list of medical advances that have generated controversy and have created issues that must be dealt with by ethical and legal regulations.

Law and medicine—two of the most ancient sciences known to mankind—have had a historically troubled coexistence, with conflicting views and concepts for the same issues. And these differences have grown even stronger in the last six decades as a result of a technological revolution in the field of medicine.

And the law can only change when required, or perhaps provoked, by these social movements, to define new limits, limitations, and rules. In other words, it must provide a solution to newly created conflicts. But it takes time. Between these two points of the journey, there is uncertainty, legal breaches, and conflict.

Not only Brazil, but the whole world is suffering from the effects of these troubled times, where law and medicine struggle to define the new

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All translations of original Brazilian texts are the author's, unless otherwise indicated.

shape of the legal rules regulating healthcare.<sup>1</sup> That is exactly why bioethics and medical law have become so prominent in the last few years.

In Brazil, we are talking about a potential market comprised of over 300,000 active physicians (not counting dentists, nurses, other health professionals, and of course, hospitals and clinics). On the opposite page, the statistics provided by the Federal Council of Medicine,<sup>2</sup> divided by state:

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1. Mariano Alonso Pérez, *La relación médico-enfermo, presupuesto de responsabilidad civil (En torno a la "lex artis")* [The doctor-patient relationship, allocating civil liability (around the "lex artis")], in *PERFILES DE LA RESPONSABILIDAD CIVIL EN EL NUEVO MILENIO* [PROFILES OF LIABILITY IN THE NEW MILLENNIUM] 13, 13 (Juan Antonio Moreno Martínez ed., 2000) (Sp.).

2. Conselho Federal de Medicina [Federal Council of Medicine], available at [www.cfm.org.br](http://www.cfm.org.br).

**Total Registered and Active Doctors in Brazil (Divided by State)**

UF	Registered	Active
AC	1115	564
AL	5208	3525
AM	5572	3250
AP	915	565
BA	20064	14582
CE	11011	7915
DF	15698	8768
ES	9372	6337
GO	13185	8492
MA	5245	3709
MG	47325	33936
MS	5667	3410
MT	4966	3283
PA	9127	5615
PB	6636	4320
PE	17045	11501
PI	3776	2532
PR	25130	16865
RJ	88034	53195
RN	5713	3739
RO	2610	1309
RR	1084	477
RS	32200	23076
SC	14586	10191
SE	3381	2428
SP	130235	96099
TO	2214	1458
<b>Total</b>	<b>437019</b>	<b>331020</b>

Source: Federal Council of Medicine, *supra* note 2.

Before we continue, there are two important data to provide, also from the Federal Council of Medicine. Although the number of administrative (ethical) claims has risen, the number of doctors considered at fault has fallen. These kinds of claims (although without economic value), have the power to harm the reputation of doctors, and in some cases, deter them from practicing medicine. Consequently, it is also important that defensive medicine become more and more a part of the product.

Gynecology, Obstetrics, and plastic surgery are the specialties most likely to face judicial claims. The graphics below show the percentages:

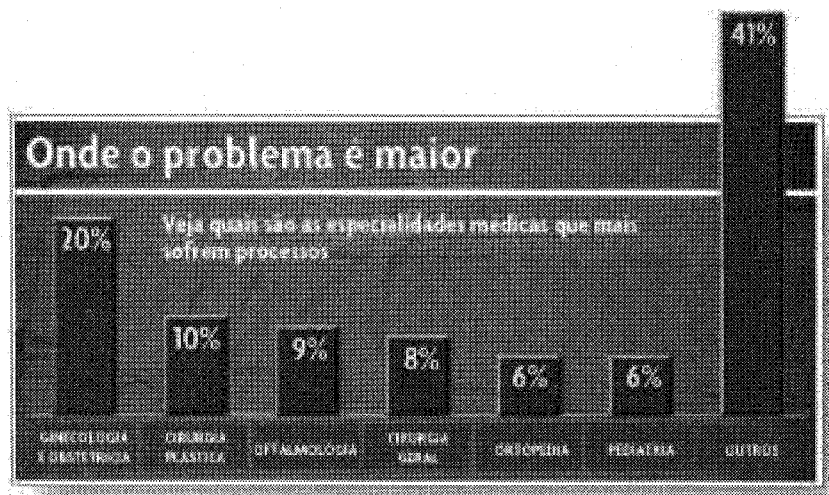


Chart Source: Federal Council of Medicine, *supra* note 2.1

## I. THE BRAZILIAN LEGAL SYSTEM

The legal systems of the world are so different and complex it is nearly impossible to explore the laws of each country individually. However, these systems share common legal problems in certain areas, like medicine, for instance.

Four common heritages (Common, Code, Islamic Law, and Socialist Law) form the basis for the majority of legal systems throughout the world. The differences are more than theoretically important because due process of law varies considerably among and within these legal systems.

Code law, the system used in Brazil, is based on a comprehensive system of written rules, or codes, of law. It is divided into commercial, civil, and criminal codes, and is highly influenced by the French, German, and Portuguese systems.

It is helpful, then, to stress the basic differences of common law and code law, as we see it. The common law, which developed in Great Britain after the Norman Conquest,<sup>4</sup> was based on the decisions of judges in the royal courts. It evolved into a system of rules based on "precedent." Whenever a judge makes a decision that is to be legally enforced, this decision becomes a precedent: a rule that will guide judges in making subsequent decisions in similar cases. The common law is unique because it cannot be found in any code or body of legislation, but exists only in past decisions. At the same time, common law is flexible and adaptable to changing circumstances.

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3. The graph titled *Justiça de Branco (White Justice)* represents the evolution of the number of Administrative Claims against physicians, tried before the Federal Council of Medicine, during a period of eight years. The red line, in a rising curve, shows the number of claims. The blue one, on the other hand, represents the number of cases where they were actually found guilty of an ethical fault. It can be interpreted in different ways: 1) The obvious conclusion is that since 1991, the number of cases has skyrocketed; 2) A small percentage of guilty physicians can either show that a) the Federal Council is being over protective; or b) Although the intolerance in the physician-patient relationship has risen, the majority of cases have no strong basis.

The graph titled *Onde o problema é maior (Where the problem is bigger)* shows that, following the general statistics about the most dangerous specialties in medicine (from the legal point of view), gynecology and obstetrics answer for 20 percent of the lawsuits, while plastic surgery represents 10 percent of the cases. Ophthalmology, general surgery, orthopedics, and pediatrics follow the list. It's not by chance that those specialties all work with positive expectations. Every single unexpected result (or even those which are normal, but weren't informed to the patient) is a potential risk of lawsuit. That strengthens even more the need for appropriate information to be disclosed to the patient, in order to prevent legal risks.

4. See R.B. Seaberg, *The Norman Conquest and the Common Law: The Levellers and the Argument From Continuity*, 24 HIST. J. 791, 794-95 (1981).

The tradition of code law is quite different. It is based on Roman law, which had been scattered about in many places—in books, in statutes, and in proclamations—until the Emperor Justinian ordered his legal experts to consolidate all the laws into a single book to avoid confusion. Ever since, code law has been associated with a “civil code.” All civil codes, such as the Code Napoleon in France, contain a comprehensive statement of rules, many of which are framed as broad, general principles designed to deal with any dispute that may arise. Unlike common law courts, courts in a code law system first look to their Code, and then refer to previous decisions for consistency.

The term “civil law” is used to mean two quite different things, which can be a little confusing at first for people trying to understand this type of justice system. Sometimes the term is used in contrast to “common law” to refer to the legal system that is based on a civil code, such as the Justinian Code or the Civil Code of Brazil. In its other sense, civil law refers to matters of private law as opposed to public law, particularly criminal law, which is concerned with harm to society at large and is present in both code law and common law systems.

In common law legal practice, judges are largely passive with respect to the production of case-specific information. Litigants are responsible for obtaining evidence, interviewing witnesses, researching the law, developing legal reasoning about the application of the law to the evidence and then conveying this to the judge. The incentives for litigants to make these investments are based on the legal rules governing judicial practice and the exercise of judicial power. Judges are generally prohibited, for example, from having *ex parte* independent contacts with witnesses or reviewing documents that are not obtained from the parties according to the rules of evidence. Common law judges may dismiss a lawsuit or enter a default judgment against a party if that party has failed to present the evidence necessary to support the application of a legal rule.

In code law systems, in contrast, judges play a more active role in obtaining evidence and, though less often, legal principles. Although litigants may provide documents in their possession and suggest potential witnesses, Brazilian judges, for example, take on significant responsibilities, such as obtaining additional documents and testimony, shaping the development of evidence, questioning witnesses and determining the order in which issues will be investigated.

These are, in short, the basic and most important differences needed to be stressed here, in order to keep in mind what kind of legal struggles we may face in litigating medical malpractice claims.

## II. THE STRUCTURE OF THE BRAZILIAN LEGAL SYSTEM

In order to comprehend the judicial process in Brazil, it is important to understand its structure, especially to stress the differences when compared to the common law system used in England and the U.S. The Brazilian system is based upon a hierarchy of norms, in which the Brazilian Federal Constitution of 1988 occupies the top space in a pyramid of authority.

Dating back to the colonial period, Brazil's legal system has been formed in part by Portuguese influence, Roman canonical law, and the German system. It differs from England and the U.S. in one fundamental way. Whereas in the common law systems, a body of law is built from the application of law by the courts, in Brazil the law is applied concretely to each specific case and judicial decisions are not completely based upon a body of jurisprudence.

Questions confronted and decided in other cases do not have the force of law in current cases being decided in Brazil; they are applicable only as a point of reflection by the Brazilian judge. In essence, English and U.S. law is decided according to judicial precedents and not by the legislation in force, as it is in Brazil.

The proliferation of legislation and legal doctrine in Brazil creates what is often viewed as a complicated and bureaucratic litigation process. Measures have been undertaken to simplify and speed up the processing of civil law in Brazil. Small claims civil and criminal courts and rules allowing parties to settle claims through arbitration have been established.<sup>5</sup>

The Brazilian Federal Constitution of 1988 was promulgated following the end of military rule in the country. It consecrates the Democratic State of Law and guarantees fundamental rights of Brazilian citizens and alien residents in the country in its most ample form as well as set within defined limits. The rights guaranteed in the Brazilian Constitution, specifically in Articles 5 and 7, which govern individual rights, are viewed as true principles of law, which inform all Brazilian legislation as well as judgments that occur in the country.<sup>6</sup>

As opposed to others, the Brazilian Congress was extremely detailed in writing the Brazilian Constitution, bringing forth general rules and obligations to be observed in diverse fields of law. In this varied range, highlights include the organization and structure of Brazilian states and the powers, rights, and obligations of public entities. It grants to the judiciary,

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5. In Brazil, mediation is regulated by Federal Law 9.306/1996, with original text available at [http://www.planalto.gov.br/ccivil\\_03/leis/L9307.htm](http://www.planalto.gov.br/ccivil_03/leis/L9307.htm).

6. Constituição Federal [C.F.] [Constitution] arts. 5, 7 (Braz.).



comprised of courts and judges, the authority to resolve disputes between private parties through the application of law.

Contrary to the common law practiced in England and the U.S., Brazilian law is based on the classical positivist school.<sup>7</sup> In other words, the law is imperative, and as such, it is imperious in its observation and application. The criteria for judging a defendant before judges or courts are governed by legislation. The Brazilian judge must apply the text of the law to the concrete case. In cases where the law does not cover the issue, the judge may use social rules for the common good to guide his judgment and sentences. In this manner, objectivity and impartiality are, in theory, preserved.

It is inevitable, however, that the vast array of laws and norms published in the country frequently end up generating inconsistencies, often allowing the reader to reach various conflicting interpretations. For this reason, there is a strong trend today toward standardizing the interpretation of laws and norms currently in force in order to arrive at a uniform application of the law. In these cases, the interpretation of a law handed down by the Federal Supreme Court, the highest court in the land, prevails.

Notwithstanding the vast array of Brazilian legislation and the positivist approach to law, the principle of the judge's right to be freely convinced and to freely appreciate the evidence brought in the process in accordance with facts and circumstances therein prevails. The judge, operating within this principle, is obliged to explain the motives for his conclusion at the end of the process.<sup>8</sup>

It is worth emphasizing at this juncture that the Brazilian judicial process is extremely formal. Judgments may only be reached in accordance with the information brought forward during the process, according to the principle of formal truth.<sup>9</sup>

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7. See Josef L. Kunz, *Contemporary Latin-American Philosophy of Law: A Survey*, 3 AM. J. COMP. L. 212, 212-13 (1954).

8. For further details about the obligation to present solid arguments in judicial ruling, we recommend reading Jasson Hibner Amaral's *Considerações acerca do dever de fundamentação das decisões*, available at <http://jus.com.br/revista/texto/8248/consideracoes-acerca-do-dever-de-fundamentacao-das-decisoes>; Sílvia Luís Saiki's *A norma jurídica da motivação das decisões judiciais*, available at [http://www.planalto.gov.br/ccivil\\_03/revista/Rev\\_88/Artigos/PDF/SilvioSaiki\\_Rev88.pdf](http://www.planalto.gov.br/ccivil_03/revista/Rev_88/Artigos/PDF/SilvioSaiki_Rev88.pdf); and Eid Badr's *Princípio da motivação das decisões judiciais como garantia constitucional*, available at <http://jus.com.br/revista/texto/14333/principio-da-motivacao-das-decisoes-judiciais-como-garantia-constitucional>.

9. For further details about the principle of formal truth in the Brazilian legal system, we recommend reading Euler Paulo de Moura Jansen's *A verdade real e a formal têm relacionamento harmônico*, available at [http://www.conjur.com.br/2008-jun-05/verdade\\_formal\\_real\\_relacionamento\\_harmonico](http://www.conjur.com.br/2008-jun-05/verdade_formal_real_relacionamento_harmonico), and Regina Lúcia Teixeira Mendes' *Princípio da*

This principle is only set aside in criminal cases, where the principle of real truth based upon the evidence guides the judge. In this, the judge is empowered to determine the production of evidence necessary to form his opinion.

In both the civil and criminal processes, the parties to the case have a right to understand the judge's motives for reaching the final decision. If this justification is not given, the final verdict is nullified. In addition, a judicial decision only becomes definitive after the appeals process has been exhausted.

In general, a single magistrate first judges the case. If the parties are not satisfied with this outcome, they may appeal to the court. Following this, an appeal to the superior court is permitted. The Federal Supreme Court is the last word in all cases, and decisions proffered by this body are definitive. As such, they may not be appealed.

A lawsuit in Brazil may take some time to reach a resolution. Depending on a number of factors (e.g., venue, judge assigned to decide, complexity of issues, and proof searching, etc.), it may take between two and ten years for the average case to conclude.

### III. THE INFLUENCE OF THE CONSUMER'S DEFENSE CODE

Were it possible to determine when the discussion of medical law started to gain importance in the Brazilian legal system, the probable date would be the year 1992, when the Consumer's Defense Code<sup>10</sup> (CDC) was enacted and put into effect. Still today, medicine is a profession that resents from the existence of a proper federal law, defining its rights and obligations, its boundaries and frontiers.

The Federal Constitution enacted in 1988 transformed the defense of consumers into a constitutional right.<sup>11</sup> Article 5, XXXII, expressly states, "The Brazilian State will promote, in the terms of the law, the defense of the consumer."<sup>12</sup> The law that the Constitution refers to is the CDC of 1992, which was the first important piece of legislation to recognize the vulnerability of common citizens in consumer transactions.<sup>13</sup>

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*verdade real no processo judicial brasileiro, available at*  
[http://www4.jfrj.jus.br/seer/index.php/revista\\_sjrj/article/viewFile/209/202](http://www4.jfrj.jus.br/seer/index.php/revista_sjrj/article/viewFile/209/202).

10. Lei No. 8.078, 11.09.1990, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 12.09.1990.

11. CAIO MÁRIO DA SILVA PEREIRA, RESPONSABILIDADE CIVIL DE ACORDO COM A CONSTITUIÇÃO DE 1988 [LIABILITY UNDER THE CONSTITUTION OF 1988] (5th ed. 1994) (Braz.).

12. C.F. art. 5; *see also* JOSÉ AFONSO DA SILVA, CURSO DE DIREITO CONSTITUCIONAL POSITIVO [POSITIVE CONSTITUTIONAL LAW COURSE] (8th ed. 1992) (Sp.).

13. Marcos Almeida Magalhães Andade Jr., *Marcadores atuais da relação médico-paciente—O palco atual onde transcorre o trabalho médico, Determinantes da deflagração dos processos judiciais*

As a result, higher courts started using the concepts of a consumer and a service provider as defined in the CDC to resolve conflicts between patients and physicians.<sup>14</sup> This application creates an almost tangible tension between the courts and the medical associations, with the latter rejecting the possibility of having the medical profession considered as a consumer-oriented relationship.

The first issue that arises is whether the practice of medicine—or in other words, the physician-patient relationship—can be viewed as a consumer/commercial relationship under the CDC.<sup>15</sup> To answer that, it is necessary to analyze the legal definitions under Brazilian law of “consumer,” “provider,” and “services.”

Article 2 of the CDC defines a consumer as “any person, individual or collective, who acquires or uses products or services as the final recipient.”<sup>16</sup>

A provider is defined by Article 3 as “any person, individual or collective, public or private, national or alien, who develops activities of production, assembly, creation, construction, transformation, import, export, distribution or selling of products or services.”<sup>17</sup>

With an exercise of interpretation of the spirit of the law, and the literal concepts included therein, it is easy to conclude that the patient, a user of medical services, is the consumer for which a service is provided (a medical procedure in general, a consultation, an intervention, or any other type of procedure), and that the healthcare professional is the provider who develops his professional activity, and is paid for it, in situations listed in the aforementioned Article 3.

The general consensus is that the patient is considered a consumer of services, regardless of whether it is a simple consultation or a complex surgical procedure, under the terms and for the purposes of the CDC. The physician offers his knowledge and services, not merely as a healthcare provider, but as a service provider, plain and simple.

*pacientes x médicos* [Current markers of the doctor-patient relationship—The current setting where medical care takes place: Determining of the triggers of medical malpractice litigation], in DIREITO & MEDICINA—ASPECTOS JURÍDICOS DA MEDICINA 21 (Arnaldo Oliveira ed., 2000) (Braz.).

14. Gerson Luiz Carlos Branco, *Responsabilidade Civil por Erro Médico: Aspectos* [Liability for Medical Error: Aspects], 4 REVISTA SÍNTESE DE DIREITO CIVIL E PROCESSUAL CIVIL [SYNTHESIS OF CIVIL LAW AND CIVIL PROCEDURE MAGAZINE], 128–151, (2000) (Braz.).

15. Sérgio Cavalieri Filho, *O direito do consumidor no limiar do século XXI* [The Right of the Consumer Approaching the 21st Century], 2 REVISTA TRIMESTRAL DE DIREITO CIVIL 123, 125–26 (abr./jun. 2000) (Braz.).

16. Lei No. 8.078, 11.09.1990, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 12.09.1990.

17. *Id.*

And that happens because there is not a specific legal definition of what constitutes a medical act or a medical service. Treated as a general rule, all regulation of healthcare falls under the CDC.

The recently enacted Medical Ethics Code (a resolution, not a law, issued by the Federal Council of Medicine) expressly excludes the possibility of considering the practice of medicine as an activity regulated by the CDC.<sup>18</sup> On the other hand, courtroom decisions apply the CDC in the rulings.<sup>19</sup>

Under the CDC, the physician-patient relationship gains new colors.<sup>20</sup> It is not just a private relationship anymore. Instead, it is heavily regulated by the law, with new rules for marketing, billing, disclosure of information,<sup>21</sup> burden of proof, and patient consent. Apart from that, empowering the patient with very favorable legal tools has boosted the number of lawsuits in the past ten years.

#### *A. Informed Consent, the Duty to Inform, and Informed Choice*

There are several legal issues regarding consent, and litigation is increasing in relation to consent issues. Several aspects need to be taken into consideration when determining whether consent was valid, such as when consent was obtained and whether the risks have been explained; moreover, whether these risks were understood by the patient (sometimes, cultural issues or language barriers can be a complication); whether the patient is a minor (and if so, whether mature enough or not to decide alone); whether an adult patient has legal capacity to decide (and also, if having legal capacity to decide, whether clinical capacity is absent); and whether an oral consent constitutes enough evidence that information has been given and understood. But, above all, the most important issue is whether the patient has been given sufficient, adequate, complete information, so that they can actually decide, and not simply acquiesce to a physician's suggestion.

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18. Resolução No. 1.931, 17.09.2009, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 24.09.2009.

19. See, e.g., S.T.J.J., REsp No. 1.180.815, Relator: Min. Nancy Andrighi, 19.08.2010, 641, Diário do Judiciário Eletrônico [D.J.e.], 26.08.2010; S.T.J.J., REsp No. 467.878, Relator: Min. Ruy Rosado de Aguiar, 05.12.2002, DIÁRIO DA JUSTIÇA [D.J.], 10.02.2003, 222.

20. Genival Veloso de França, *O Código do Consumidor e o exercício da medicina* [The Consumer Code and the Practice of Medicine], BUSCA LEGIS, available at <http://www.egov.ufsc.br/portal/sites/default/files/anexos/24742-24744-1-PB.pdf> (Braz.).

21. See ADALBERTOS PASQUALOTTO, OS EFEITOS OBRIGACIONES DA PUBLICIDADE NO CÓDIGO DE DEFESA DO CONSUMIDOR [THE EFFECTS OF ADVERTISING ON THE CONSUMER DEFENSE CODE] (1997) (Braz.).

Very often, though, physicians and healthcare providers misunderstand the concept of so-called informed consent.<sup>22</sup>

Informed consent is the authorization given by the patient to undergo treatment, based on the knowledge of the nature of a medical procedure, and to be exposed to risks, side effects, possible complications, benefits and alternatives to the proposed treatment.<sup>23</sup> In other words, it is the acceptance of the services to be delivered by a healthcare professional after understanding what is being consented to.

It is necessary to understand that the process of consenting constitutes, simultaneously, a patient's right and a physician's duty.<sup>24</sup> Yet this notion is not well understood among Brazilian physicians. It is yet to be understood by a vast majority of them that the patient must be informed in a clear and comprehensible way, according to his cognitive capabilities, about his diagnosis, risks, prognosis, and existing treatment alternatives, including those the doctor does not think are appropriate for the patient.

It is also important to point out that the mere act of reading and signing a consent form is not enough to release the physician from his duties, from his obligation to inform accordingly (even if this written form is an important piece of evidence of due diligence).

The right to be informed has little or nothing to do with the true exercise of the patient's autonomy. The act of consenting to some treatment, research, experiment, or surgical procedure is just a part of a bigger process, where the patient can exercise autonomy. Someone can consent based on his trust in the doctor, based on indifference, fear, or even because he did not receive all the information necessary to meaningfully choose among possible options.

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22. RUTH FADIN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 237 (1986) ("It is always an open question whether an autonomous person with the capacity to give an informed consent actually has, in any specific instance, given an informed consent, in the sense of making an autonomous choice to authorize or refuse an intervention.").

23. See EDUARDO DANTAS, DIREITO MÉDICO 71-105 (Editora GZ 2009).

24. See, e.g., Resolução No. 1.931, 17.09.2009, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 24.09.2009, art. 22 (Braz.) ("[The physician shall not] fail to obtain consent from the patient or the patient's legal representative after a full disclosure of any procedure to be performed, except in the case of imminent risk of death."); *id.* at art. 24 ("[The physician shall not] prevent the patient from exercising the right to decide freely on his own personal well-being as well as exercise his authority to limit it."); *id.* at art. 26 ("[The physician shall not] fail to respect the will of any person, capable physically and mentally, on hunger strike, or forcibly feed him, providing him with information about possible complications of prolonged fasting, and in the assumption of risk of imminent death, treating it."); *id.* at art. 31 ("[The physician shall not] disregard the right of the patient or the patient's legal representative to decide freely on the performance of diagnostic or therapeutic practices, except in case of imminent risk of death."); *id.* at art. 34 ("[The physician shall not] fail to inform the patient about the diagnosis or prognosis, or the risks and goals of treatment, except when direct communication may cause the patient damage, in which case, the communication shall be delivered to the patient's legal representative.").

Informed consent is often confused with informed choice, the latter being essential to achieve the fulfillment of the right to be informed (and the physician's duty to inform). The patient needs not only to receive, but also to understand the information that is being conveyed. Information without comprehension is legally void, because it could be proven that the patient consented (or signed a consent form), but did not exercise his right to free and informed choice. His autonomy would be jeopardized.

And what is appropriate information? That is a difficult question, since the answer may differ, given the specific situation. But mostly, the communication between the physician and his patient must include the existing treatment options (not only the main options) with their purposes and details, their benefits and risks (commonly occurring risks and those unlikely to occur), possible side effects, success rates, the reasons why a specific option is being recommended, the prognosis, and the risks of not getting treatment.<sup>25</sup>

That being said, the act of obtaining consent without allowing proper choice does not represent an automatic release from professional duties regarding information, if it was withheld, distorted, tampered with, or incomplete. The physician would still be held liable for informational negligence.<sup>26</sup>

The examples of legal documents could go on and on, in Brazil,<sup>27</sup> Portugal,<sup>28</sup> Spain<sup>29</sup>, France<sup>30</sup> and Israel,<sup>31</sup> and all over the world, showing that

25. See EDUARDO DANTAS, *DIREITO MÉDICO* 71–105 (Editora GZ 2009).

26. See S.T.J.J., REsp No. 1.071.969, Relator: Min. Luis Felipe Salomão, 02.02.2010, 527, Diário do Judiciário Eletrônico [D.J.e.], 01.03.2010 (Braz.) (The Superior Court of Justice decided in favor of the plaintiff, holding a blood bank liable for lack of proper communication of test results.); S.T.J.J., AgRg No. 818.144, Relator: Min. Ari Pargendler, 09.10.2007, 23, Diário do Judiciário Eletrônico [D.J.e.], 05.11.2007 (Braz.) ("The physician who does not inform his patient about the risks of surgery is negligent, being liable for all damages resulting from the intervention."); but see S.T.J.J., REsp No. 1.051.674, Relator: Min. Massami Uyeda, 23.04.2003, 349, Diário do Judiciário Eletrônico [D.J.e.], 24.04.2009 (Braz.) (exempting the doctor from being considered responsible for an unexpected result, because he proved the fulfillment of the duty to inform). All three rulings available at [www.stj.jus.br](http://www.stj.jus.br).

27. See, e.g., Lei No. 10.741, 1.10.2003, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 3.10.2003 (Braz.) (The Elderly Protection Act ensures the right to choose the most favorable health treatment.); Lei No. 9.434, 4.02.1997, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 5.02.1997 (Braz.) (The Organ and Tissues Transplantation Law requires consent for every procedure.); Lei No. 8.080, 19.09.1990, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 20.09.1990 (Braz.) (The Health Organization Law article 7, section V, reinforces to the patient the right to information about his/her health conditions.). State law also regulates patients' rights. See, e.g., Lei No 16.279, 20.07.2006, DIÁRIO DA MINAS GERAIS [D.O.E.M.G.], 21.07.2006 (Braz.); Lei No 14.254, 4.12.2003, DIÁRIO OFICIAL DA PARANÁ [D.O.E.P.], 23.12.2003 (Braz.); Lei No 10.204, 7.01.1999, DIÁRIO OFICIAL DA SAO PAULO [D.O.E.S.P.], 8.01.1999 (Braz.).

28. Regulamento 14/2009, D.R. II. Série 8, 13 Jan. 2009, 1355–1369, art. 44–51 (Port.).

29. Básica Reguladora de la Autonomía del Paciente y de Derechos y Obligaciones en Materia de Información y Documentación Clínica [Basic Law on Patient Autonomy and Rights to Information and Clinical Documentation] (B.O.E. 2002, 22188) (Sp.).

30. Loi 2002-303 du 4 mars 2002 de relative aux droits des maladies et à la qualité du système de santé [Law 2002-303 of March 4, 2002 on Patients' Rights and the Quality of the Health System],

there is a new way of dealing with old dilemmas, and that healthcare providers must modify their practices to conform to emerging standards. The world has evolved, and that requires adaptation.

It is a mistake to think that obtaining informed consent—as it happens today in most cases—is enough to exempt the physician from liability, absolving legal responsibility in the event an undesired outcome occurs during the treatment or procedure.

A treatment or procedure can be considered successful from a clinical point of view, but later be seen as inappropriate when compared to other possible outcomes that could be expected if a different therapeutic method had been explained to and chosen by the patient.

This lack of information does not necessarily constitute negligence. It may represent the expression of the physician's beliefs, based in his own experience or in the medical literature, that the course of treatment taken was the most appropriate for the situation faced at that moment. The problem is that this behavior goes against ethical principles and legal commands that make mandatory the disclosure of all information available. Withholding information about alternatives may be considered, in a lawsuit or in a disciplinary investigation, an undue interference in treatment and a breach of confidence that is contrary to the principles promoting good-faith and patient autonomy.<sup>32</sup>

*B. Moral Damages and the Inversion of the Burden of Proof As Patient's Basic Rights*

The CDC offers, in its Article 6, a list of what is considered the “consumer's basic rights,” and among them “the effective prevention and reparation of material and moral damages” (item VI) and “easy access to the defense of consumers' rights, including the reversal of the burden of proof, in civil procedures, if the judge finds it reasonable, according to the ordinary rules of experience.” (item VIII).<sup>33</sup> The Brazilian Constitution also

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JOURNAL OFFICIEL DE LA RÉPUBLIQUE FRANÇAISE [J.O.] [OFFICIAL GAZETTE OF FRANCE], Mar. 5, 2002, p. 4118 (Fr.); see also Loi 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie [Law 2005-370 of 22 April, 2005 on Patients' Rights and End of Life], J.O., Apr. 23, 2005, p. 7089 (Fr.).

31. Patients' Rights Law, 5756-1996, SH No. 327 (Isr.).

32. See EDUARDO DANTAS, DIREITO MÉDICO 71-105 (Editora GZ 2009).

33. Lei No. 8.078, 11.09.1990, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 12.09.1990.

provides grounds for the compensation for moral damages<sup>34</sup> in Article 5, X.<sup>35</sup>

Contrary to the general rule established in the procedural law, the burden of proof can also be shifted to fall upon the defendant's shoulders. If a judge finds it reasonable to determine that the plaintiff does not have the means (either financially or technically) to prove his allegations, this burden can be transferred to the physician, who must prove that no harm was done, or that the adverse event was not caused by negligence, imprudence, or lack of expertise.<sup>36</sup> It is the no-fault system taken to the extreme, contributing to an increase of groundless litigation.<sup>37</sup> As a result of all these "rights," the system is overloaded with cases that take long to analyze, and will be dismissed in the end.

#### IV. THE CHANGES BROUGHT BY THE NEW CIVIL CODE

In January 2003, a new Civil Code was enacted in Brazil, represented by the Federal Law 10.406/2002,<sup>38</sup> replacing the eighty-seven-year-old Civil Code of 1916.<sup>39</sup> Almost nine decades separating these two documents could lead to great expectations for change and innovation. At least in tort law, they did not come true.

In general, there has been merely a semantic recycling, with different words for identical commands. As an example, Article 927 replaced the 1916's Article 159:

Article 927 (2002). Who, by an unlawful act (articles 186 and 187) harm others, is obliged to repair it.

Sole Paragraph. There will be an obligation to repair the damage, regardless of fault, in the cases specified by law, or when the activity normally carried out by the perpetrator imply, by its nature, risk to the rights of others.

Article 159 (1916). Who, by voluntary act or omission, negligence, or recklessness, violate the rights, or cause injury to others, is obliged to repair the damage.

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34. Danielle Machado Soares, *O Médico e sua Responsabilidade* [The Doctor and His Responsibility], 1 REVISTA DE RESPONSABILIDADE CIVIL, 15–34 (2000) (Braz.).

35. C.F. art. 5 ("Intimacy, private life, honor, and image of persons are inviolable and the right to compensation for property or moral damages resulting from the violation thereof shall be ensured.")

36. LUIZ ANTONIO RIZZATTO NUNES, COMENTÁRIOS AO CÓDIGO DE DEFESA DO CONSUMIDOR [COMMENTS TO THE CODE OF CONSUMER PROTECTION], (1st ed. 2000) (Braz.).

37. Jane Courtes Lutzky, *El Código de Defensa del Consumidor y la responsabilidad personal del médico en la República Federativa del Brasil* [THE CONSUMER CODE AND THE PERSONAL RESPONSIBILITY OF THE PHYSICIAN IN THE FEDERATIVE REPUBLIC OF BRAZIL], in, CUADERNOS DE BIOÉTICA [JOURNAL OF BIOETHICS], 101–09 (1997) (Braz.).

38. Lei No. 10.406, 10.01.2002, DIÁRIO OFICIAL DA UNIÃO [D.O.U.], 11.01.2002.

39. Federal Law 3.071/1916.



In principle, one could imagine that the new code is concerned only with the harm caused by wrongful acts, and that the old definitions, encompassing voluntary acts or omissions, negligence or recklessness, would be more complete. However, one must look at the code as an integrated system, so that hermeneutic interpretation is made according to a set, whether or not cohesive.

In this light, it is necessary to consider Articles 949 to 951 of the new law, which relate directly to possible problems caused by malpractice in the practice of medicine and certainly present in many lawsuits.

The only addition that can be considered timely innovation is the inclusion of what was already being applied by the Superior Courts, as is the case of the sole paragraph of Article 950, transcribed below.

Article 949 (2002). In case of injury to health or other offense, the offender shall indemnify the offended for the cost of treatment, for the profits not earned until the end of convalescence, and some other injury that the victim proves to have suffered.

Article 1.538 (1916). In the case of injury to health or other offense, the offender shall indemnify the offended for the cost of treatment or for the profits not earned until the end of convalescence, and to pay a fine in the importance of the average degree felony accordingly.

Article 950 (2002). If the offense results in an injury that prevents the injured person from conducting such person's business or profession, or reduces the ability of the injured person to perform job duties, compensation, plus the cost of treatment and lost earnings until the end of convalescence, will include a pension corresponding to the nature of the work that the injured person is prevented from doing.

Sole Paragraph. The injured person may require that compensation be arbitrated and paid in one installment.

Article 1.539 (1916). If the offense results in an injury that prevents the injured person from conducting such person's business or profession, or reduces the ability to work, compensation, plus the cost of treatment and lost earnings until the end of convalescence, will include a pension corresponding to the nature of the work that the injured person is prevented from doing.

This hypothesis conforms to situations where, because of medical malpractice the patient loses, for example, major motor functions, disabling him from working.

The Article does not mention the complete inability to work (leaving this issue for the subsequent Article). Rather it deals only with the situation when the injured person is unable to exercise his profession, or when the quantity or quality of his performance is significantly reduced. Thus, factors such as evidence backed by technical expert reports, average market values for the services provided by the victim, degree of specialization of

the victim, average salary, financial capacity, and economic potential of the offender are relevant in determining a fair measure of damages—all this without prejudice to any criminal or disciplinary sanctions, to be discussed in the appropriate forum.

Article 951 (2002). The provisions of Articles 948, 949, and 950 also apply in the case of compensation payable by a person, in the exercise of professional activity, whose negligence, imprudence or inexperience, causes the death of the patient, aggravate the harm, cause him injury, or disqualify him for employment.

Article 1.545 (1916). Physicians, surgeons, pharmacists, midwives and dentists are liable for damage which, when due to recklessness, negligence or malpractice in professional acts, results in death, inability to serve, or injury.

There was the intention of expanding the scope of the Article so as to make it a reference to professional liability in general, not just to medical activity.

However, the use of the term “patient” restricts the Article’s application to doctors, surgeons, pharmacists, dentists, nurses, anesthesiologists, and all other healthcare professionals. The new Article, even though paradoxically more general, gains in precision, expanding its applicability.

The new Article, when examined in practice, brings no change, since the chances of application remain the same, and the other job categories not mentioned in the old Article had already been treated this way by national courts.

## CONCLUSION

The defense of the consumer has developed considerably in recent decades to become an autonomous branch of law.<sup>40</sup> At the same time, there has been an evolution in the concepts that guide the physician-patient relationship, on account of the progress in the medical sciences, which have become too specific on one hand, and extremely popular on the other. There has been a depersonalization of services, and the demystification of the medical profession.

These two movements combined have laid the groundwork for the formation of a new understanding, a new view on the legal nature of medical activity, with direct consequences on the rules established to guide the relationships arising from there.

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40. ADA PELLEGRINI GRINOVER ET AL., *CÓDIGO BRASILEIRO DE DEFESA DO CONSUMIDOR COMENTADO PELOS AUTORES DO ANTEPROJETO* [THE DRAFTERS’ COMMENTS TO THE BRAZILIAN CODE OF CONSUMER DEFENSE] (6th ed. 1999) (Braz.).

In Brazil, the legislative amendment of concepts occurred rapidly, and received extensive support from the courts, thereby driving the improvement of the rules themselves.

In principle, the aversion to change in some sectors is understandable. There is no denying, however, that it is positive for the people that matter: the patients, the consumers of medical services. Most importantly, the changes help to clarify the rules of procedure between the parties. There are only benefits to good people, those concerned about treating their patients effectively, and those who embrace their profession.

The arguments explained above are not intended to be immutable ideas. They are, however, contribution to the debate, critical thinking that seeks to illuminate some points still considered controversial by some.

For Brazil, it is undeniable the complete and perfect applicability of the CDC to the medical activity, improving the existing rules, especially those inserted into the Code of Medical Ethics. The tendency towards this subject proves irreversible, and the obligation of doctors, lawyers, and other actors is to identify ways to improve rules using their everyday experience to bring security (legal and procedural) to healthcare providers and their patients.